Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

May 3, 2006

Ms. Shannon R. Turner, J.D.
Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621-0001

Attention: Stephanie Brammer-Barnes

Dear Ms. Turner:

We are pleased to inform you that Kentucky's Medicaid reform plan is being approved today. In order to implement the Governor's plan, State Plan Amendments (SPAs) submitted under the following transmittal numbers are approved: 06-006; 06-007; 06-008; and 06-010.

On April 20, 2006, the Commonwealth of Kentucky submitted multiple SPAs as part of a larger Medicaid reform effort. The overall guiding principles of the Commonwealth's Medicaid reform program are to promote and improve the health status of its beneficiaries, to ensure beneficiaries receive timely and appropriate care in the right setting, and to empower beneficiaries to be active participants in their own healthcare.

Kentucky is implementing most of its reform program through the flexibilities granted under the Deficit Reduction Act of 2006 (DRA). The Commonwealth will introduce health plans tailored to better meet the needs of specific populations through the use of benchmark plans granted under section 6044 of the DRA, State Flexibility in Benefit Packages, which added section 1937 of the Social Security Act (the Act). The approval of SPA number 06-010 allows the State to provide alternative benefit packages for Medicaid beneficiaries. Kentucky will also implement a non-emergency medical transportation (NEMT) brokerage program (SPA 06-008) through section 6083 of the DRA, which added a new section 1902(a)(70) of the Act.

The approval of these SPAs will allow the Commonwealth to:

- Provide four population specific benefit packages that vary in amount, duration and scope for optional services, resulting in tailored benefit packages that meet population specific health care needs (SPA 06-007; 06-010);
- Require beneficiaries to share in the cost of covered services; however for those individuals covered under the benefit flexibility of DRA, cost sharing has been reduced from current Medicaid State plan levels (SPA 06-006; 06-010);

- Provide Disease Management Programs that will be developed and phased in by geographic area to assist beneficiaries with specific chronic illnesses. Also, "Get Healthy" Benefits will be established under the Disease Management Program, to provide incentives to Medicaid beneficiaries practicing healthy behaviors (SPA 06-010); and
- Promote private health insurance coverage. All Kentucky Health Choices beneficiaries, with the exception of children, may elect to voluntarily opt-out of Medicaid into Employer Sponsored Insurance (ESI) when the beneficiary has access to ESI (SPA 06-010).

Prior to implementation, the Department for Medicaid Services must comply with Federal requirements of advance public notice, which can include, but are not limited to State website posting or public service announcements.

Approval of the these SPAs is limited to the scope of the submitted benefit provisions and does not constitute approval of any change in reimbursement methodologies, new reimbursement methodologies, or change in the sources of non-Federal share funding utilized by the Commonwealth to make such Medicaid payments.

Enclosed is a copy of the approved plan pages and the HCFA-179 forms. If you have any questions, please contact Ms. Jean Sheil, Director of the Family and Children's Health Programs Group at 410-786-5647. We congratulate Kentucky on its pioneering efforts to implement the flexibility afforded to states under the DRA.

Sincerely,

Roger Perez
Acting Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

2: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 06-010

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 15, 2006

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Deficit Reduction Act of 2005 [Section 1937 of the Social Security Act]

7. FEDERAL BUDGET IMPACT:
a. FFY 2006 (Decrease of expenditures by approximately 2,686,268.60 for Comprehensive Choices (May 15 – Sept. 30, 2006) Budget neutral for Family Choices
b. FFY 2007 (Decrease of expenditures by approximately 24,090,174 for Comprehensive Choices (May 15 – Sept. 30, 2006) Budget neutral for Family Choices

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-C, pages 10 – 10.31

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Preprint pages – New to the State Plan

10. SUBJECT OF AMENDMENT:
Alternative Benefits – Family Choices and Comprehensive Choices Benefit Packages

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Shannon Turner, J.D.

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED:

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 21, 2006

18. DATE APPROVED: May 3, 2006

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2006

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Roger Perez

22. TITLE: Acting Regional Administrator

23. REMARKS: Approved with the following changed authorized by the State Agency on e-mail dated May 4, 2006: Item 4 changed to read: "April 1, 2006 with an implementation date of May 15, 2006"; Item 7a: Add "1,130,000 for Optimum Choices (May 15-Sep 30, 2006)"; Item 7b: Add "7,310,000 for Optimum Choices (May 15-Sep 30, 2006)"; Item 8: Changed to read "Attachment 3.1-C, pages 10-10.40"; Item 9: Changed to read: "New". Item 8: Add "Appendix 1 to Attachment 3.1-C, Pages 1-3".

FORM HCFA-179 (07-92)

ALTERNATIVE BENEFITS

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1937(a), 1937(b)

X/ The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

a. X/ Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

Family Choices which means children covered pursuant to:
Sections 1902 (a)(10)(A)(i)(I) and 1931 of the Act
Sections 1902(a)(52) and 1925 of the Act (Excluding children eligible under Part A or E of title IV)
Sections 1902 (a)(10)(A)(i)(IV) as described in 1902 (l)(1)(B) of the Act
Sections 1902 (a)(10)(A)(i)(VI) as described in 1902 (l)(1)(C) of the Act
Sections 1902 (a)(10)(A)(i)(VII) as described in 1902 (l)(1)(D) of the Act
42 CFR 457.310

b. X/ Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

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List the populations/individuals who will be offered opt-in alternative coverage:

Comprehensive Choices
The Comprehensive Choices package will be available to all individuals who meet the nursing facility level of care and receive services through either a nursing facility or one of the following 1915 c waivers: Acquired Brain Injury, Home and Community Based or Model II.

Comprehensive Choices EG 4	Federal Poverty Level
Mandatory State Plan Populations	
Aged individuals who receive SSI and meet NF level of care and are in hospice	Up to 74%
Disabled individuals who receive SSI and meet NF level of care and are in hospice	Up to 74%
Non-Mandatory State Plan Populations	
Aged individuals who do not receive SSI and meet NF level of care	Up to 221%
Disabled individuals who do not receive SSI and meet NF level of care, including those served by the ABI waiver	Up to 221%
Aged individuals who do not receive SSI and meet NF level of care and are in hospice	Up to 221%
Disabled individuals who do not receive SSI and meet NF level of care and are in hospice	Up to 221%

Optimum Choices
The Optimum Choices package will be available to all individuals who meet the intermediate care facility for individuals with mental retardation or a developmental disability level of care and receive services through either an intermediate care facility for individuals with mental retardation or a developmental disability or through the 1915 c Supports for Community Living waiver.

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Optimum Choices EG 4	Federal Poverty Level
Mandatory State Plan Populations	
Aged individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74%
Disabled individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74%
Non-Mandatory State Plan Populations	
Aged individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221%
Disabled individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221%
Aged individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221%
Disabled individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221%

Employer Sponsored Insurance (ESI):

Except for the following exclusions, ESI will be available to all members who elect ESI coverage. Individuals excluded from the ESI option include all children, including but not limited to, those covered pursuant to:
Section 1634(c) and 1634(d)(2) of the Act;
Sections 1902(a)(10)(A)(i)(I) and 1931 of the Act;
Section 1902(a)(10)(A)(i)(II) of the Act;
Sections 1902(a)(10)(A)(i)(IV) as described in 1902 (l)(1)(B) of the Act;
Sections 1902(a)(10)(A)(i)(VI) as described in 1902 (l)(1)(C) of the Act;
Sections 1902(a)(10)(A)(i)(VII) as described in 1902 (l)(1)(D) of the Act;

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Sections 1902(a)(52) and 1925 of the Act; 42 CFR 435.120, 435.134, 435.135, 435.137, 435.138, 435.145, 435.227, 435.320. 435.322, and 435.324; 42 CFR 457.310

Individuals who voluntarily elect ESI coverage will be subject to the benefit package, cost sharing and co-payment provisions of the ESI. The ESI benchmark equivalent plan will be the Kentucky State Employee Essential Health Insurance Plan (please see Appendix 1 to Attachment 3.1-C). Kentucky Medicaid will not provide wrap around services to individuals enrolled in ESI.
For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

The State will send to each eligible member a letter notifying them of the benefits and cost sharing associated with participation in the Comprehensive Choices and Optimum Choices benefit packages. The cost sharing under the Comprehensive Choices plan and the Optimum Choices plan is less than the cost sharing under the Global Choices plan due to the unique level of care.

The State will send to each eligible member a letter notifying them of the Employer Sponsored Insurance option. When an individual initially applies for Kentucky Medicaid or applies for recertification, the

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eligibility intake worker will offer the individual the opportunity to opt in to Employer Sponsored Insurance. The worker will provide informational materials to the individual explaining ESI and noting that the ESI may offer less benefits than those offered via the traditional Medicaid benefit package. The material shall contain a statement that the individual may opt out of the ESI plan at any time and revert back to appropriate Medicaid coverage.

If the individual elects ESI coverage, he/she will be asked to sign appropriate documentation denoting his/her election and the eligibility worker will request a copy of the individual's ESI plan Schedule of Benefits.

The worker will forward the ESI Schedule of Benefits along with the individual's ESI opt-in form to the Medicaid contractor that administers the State's Health Insurance Premium Plan (HIPP) program for the State. The contractor will determine if the benefits offered under the ESI plan are equivalent to the benchmark plan and if the plan is cost effective and meets economy and efficiency principles.

If the ESI plan benefits equal the benchmark plan benefits, is cost effective for the State and meets economy and efficiency principles a letter will be sent to the individual accepting their request to opt in to the ESI plan. If the ESI plan fails to meet the above tests, the individual will be sent a letter notifying that their request

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for ESI was not accepted due to failing to meet whichever criteria it did not meet. Thus, the State will ultimately maintain discretion as to whether or not to offer ESI coverage to an individual.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.
Please see the attached benefit grid for Comprehensive Choice and Optimum Choices. Cost sharing for this population is reduced under this benefit design.

The Kentucky State Employee Essential Health Insurance Plan (please see attached) will be the benchmark equivalent plan utilized for individuals selecting Employer Sponsored Insurance.

c. X/ Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:
Targeted disease management benefits will be made available to certain counties based on diagnosis of applicable disease state.

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography

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limitations, or any other requirements or limitations. ***Please see the attached listing of disease management program descriptions and their corresponding geographic locations. All Medicaid eligibles with an appropriate diagnosis code, who are capable of meeting the participation requirements of the related disease management program, may elect to participate in the disease management program if offered in their county of residence. All enrollments will be opt-in, participation will not be mandated.***

B. Description of the Benefits

X/ The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1. X/ Benchmark Benefits

a. __/ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

b. __/ **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State's employee benefits plan package.

c. __/ **Coverage Offered Through a Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has

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the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.

d. X / **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

Please see the attached Family Choices benefit description, Comprehensive Choices benefit description, Optimum Choices benefit description and Disease Management program descriptions.

2. X / Benchmark-Equivalent Benefits. Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: **The Employer Sponsored Insurance (ESI) plan will be equivalent to the State's State Employee Essential Health Insurance Plan which is attached.**

The State will send to each eligible member a letter notifying them of the Employer Sponsored Insurance option. When an individual initially applies for Kentucky Medicaid or applies for recertification, the eligibility intake worker will offer the individual the opportunity to opt in to Employer Sponsored Insurance. The worker will provide informational materials to the individual explaining ESI and noting that the ESI may

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offer less benefits than those offered via the traditional Medicaid benefit package. The material shall contain a statement that the individual may opt out of the ESI plan at any time and revert back to appropriate Medicaid coverage.

If the individual elects ESI coverage, he/she will be asked to sign appropriate documentation denoting his/her election and the eligibility worker will request a copy of the individual's ESI plan Schedule of Benefits.

The worker will forward the ESI Schedule of Benefits along with the individual's ESI opt-in form to the Medicaid contractor that administers the State's Health Insurance Premium Plan (HIPP) program for the State. The contractor will determine if the benefits offered under the ESI plan are equivalent to the benchmark plan and if the plan is cost effective and meets economy and efficiency principles.

If the ESI plan benefits equal the benchmark plan benefits, is cost effective for the State and meets economy and efficiency principles a letter will be sent to the individual accepting their request to opt in to the ESI plan. If the ESI plan fails to meet the above tests, the individual will be sent a letter notifying that their request for ESI was not accepted due to failing to meet whichever criteria it did not meet. Thus, the State will ultimately maintain discretion as to whether or not to offer ESI coverage to an individual.

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a. X / The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. X / The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of

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that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. X / The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) __/ **Inclusion of Basic Services** - This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

/ Inpatient and outpatient hospital services;
/ Physicians' surgical and medical services;
/ Laboratory and x-ray services;
/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices
/ Other appropriate preventive services, as designated by the Secretary.
/ Clinic services (including health center services) and other ambulatory health care services.
/ Federally qualified health care services
/ Rural health clinic services
/ Prescription drugs
/ Over-the-counter medications
/ Prenatal care and pre-pregnancy family services and Supplies

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/ Inpatient Mental Health Services not to exceed 30 days in a calendar year
/ Outpatient mental health services furnished in a State-operated facility and including community-based services
/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
/ Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
/ Dental services
/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
/ Outpatient substance abuse treatment services
/ Case management services
/ Care coordination services
/ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.
/ Premiums for private health care insurance coverage
/ Medical transportation
/ Enabling services (such as transportation, translation, and outreach services
/ Any other health care services or items specified by the Secretary and not included under this section

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The State will maintain a list of all services covered by each ESI plan utilized by individuals who voluntarily select ESI coverage.

(2) Additional benefits for voluntary opt-in populations:
__/ Home and community-based health care services
__/ Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

Please see attached Kentucky state employee benefit grid and the table outlining the differences between that plan and Family Choices.

3. Wrap-around/Additional Services

a. X / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

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EPSDT services will be provided by the State to insure that the full EPSDT benefit is available when medically necessary.

b. __/ The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1. __/ The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

2. __/ The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).

3. __/ The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirement.

4. __/ Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

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5. X / Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

At the inception of the Family Choices program, the alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).

Post implementation the State intends to bid out the plan to be administered through a managed care entity.

Premium assistance will be provided to recipients opting into employer sponsored insurance coverage with benchmark-equivalent benefits.

D. Additional Assurances

a. X / The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. X / The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

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E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

X / The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

X / The State will implement this State Plan amendment on ***May 15, 2006.***

H. Signature

Date: 4-19-06

Authorizing Official: Shannon Turner, JD
Commissioner

Authorizing Official's
Signature:_____

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Family Choices Attachments

The Family Choices benefit package was based on the Kentucky state employee benefit package with modifications to assure nominal cost sharing. Some benefit limit and design changes were also made to the package. Limits imposed under the Family Choices plan are soft limits which means additional visits may be authorized if medically necessary; in contrast, the limits in the state employee health benefit plan are hard limits and may not be exceeded. The differences are detailed in the following table:

State Employee Benefit	Family Choices Benefit
Chiropractic Services- 26 per visits per year	Chiropractic Services- 7 visits per 12 months
Speech Therapy- 30 visits per year	Speech Therapy- 15 visits per year
Physical Therapy- 30 visits per year	Physical Therapy- 15 visits per year
Occupational Therapy- 30 visits per year	Occupational Therapy- 15 visits per year
EPSDT (not fully covered)	EPSDT
Home Health- limited to 60 visits per year	Home Health- 25 visits per 12 months
Skilled Nursing Facility Services- limited to 30 days per year	Skilled Nursing Facility Services- no day limitation

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The Following table outlines the benefit package for Family Choices. The cost sharing requirements listed in this benefit grid will apply to all members of Family Choices. For the Family Choices populations, these cost sharing requirements shall supersede any other cost sharing requirements described elsewhere in the state plan.

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
Medical Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months
Acute Inpatient and Critical Access Hospital Services	$0 co-pay	$0 co-pay	$0 co-pay
Laboratory, Radiology and Diagnostic	$0 co-pay	$0 co-pay	$0 co-pay
Physician Services	$0 co-pay	$0 co-pay	$0 co-pay
EPSDT Services for Children under 21	$0 co-pay	$0 co-pay	Not covered
Outpatient Hospital/Ambulatory Surgical Centers	$0 co-pay	$0 co-pay	$0 co-pay
Behavioral Health Services	$0 co-pay	$0 co-pay	$0 co-pay
Allergy Services	• $0 co-pay	• $0 co-pay	• $2 co-pay for office visit and testing • $0 co-pay for injections
Preventive Services	$0 co-pay	$0 co-pay	$0 co-pay
Emergency Ambulance	$0 co-pay	$0 co-pay	$0 co-pay

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Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
Dental Services Including but not limited to Children under 21, two cleanings per 12 months, one set of x-rays per 12 months, extractions.	$0 co-pay	$0 co-pay	$0 co-pay
Family Planning	$0 co-pay	$0 co-pay	$0 co-pay
Occupational Therapy	$0 co-pay 15 visits per 12 months for each therapy	$0 co-pay 15 visits per 12 months for each therapy	$0 co-pay 15 visits per 12 months for each therapy
Physical Therapy	$0 co-pay 15 visits per 12 months for each therapy	$0 co-pay 15 visits per 12 months for each therapy	$0 co-pay 15 visits per 12 months for each therapy
Speech Therapy	$0 co-pay 15 visits per 12 months	$0 co-pay 15 visits per 12 months	$0 co-pay 15 visits per 12 months
Hospice (non-institutional)	$0 co-pay	$0 co-pay	$0 co-pay
Non-Emergency Transportation (will be provided for all groups except BCCTP members as described in the current 1915b waiver)	Not Covered	Not Covered	Not Covered
Chiropractic Services	$0 co-pay 7 visits per 12 months	$0 co-pay 7 visits per 12 months	$0 co-pay 7 visits per 12 months

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
Prescription Drugs	$0 co-pay	$0 co-pay	$1 generic $2 preferred $3 non-preferred brand prescriptions
Emergency Room	$0 co-pay	$0 co-pay	5% coinsurance for non-emergency use
Hearing Aids and Audiometric Services	$0 co-pay	$0 co-pay	$0 co-pay
	$1,400 maximum per ear every 36 months; 1 audiologist visit per 12 months; children under 21 ONLY	$1,400 maximum per ear every 36 months; 1 audiologist visit per 12 months; children under 21 ONLY	$1,400 maximum per ear every 36 months; 1 audiologist visit per 12 months; children under 21 ONLY
Vision Services General ophthalmology and optometry	$0 co-pay	$0 co-pay	$0 co-pay
	$400 maximum on eyewear per 12 months; children under 21 ONLY	$400 maximum on eyewear per 12 months; children under 21 ONLY	$400 maximum on eyewear per 12 months; children under 21 ONLY
Prosthetic Devices	$0 co-pay	$0 co-pay	$0 co-pay
	$1,500 per 12 months	$1,500 per 12 months	$1,500 per 12 months
Home Health Services	$0 co-pay	$0 co-pay	$0 co-pay
	25 visits per 12 months	25 visits per 12 months	25 visits per 12 months

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
DME	$0 co-pay	$0 co-pay	$0 co-pay
Substance Abuse	$0 co-pay	$0 co-pay	$0 co-pay
	EPSDT only	EPSDT only	EPSDT only

* **Physician Services** include physicians, certified pediatric and family nurse practitioners, nurse midwives, FQHCs, rural health clinics and physician assistants.
Behavioral Health Services include mental health rehab/stabilization, behavioral support, psychological services and inpatient psychiatric services under the age of 21.

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Comprehensive Choices and Optimum Choices Benefit Plan

The following table outlines the benefit package for Comprehensive Choices and Optimum Choices. The cost sharing requirements listed in this benefit grid will apply to all members of Comprehensive Choices and Optimum Choices. For the Comprehensive Choices and Optimum Choices populations, these cost sharing requirements shall supersede any other cost sharing requirements described elsewhere in the state plan.

Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Medical Out-of-Pocket Maximum	No Maximum	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	No Maximum	$225 per 12 months
Acute Inpatient and Critical Access Hospital Services	$50 co-pay per admission	$10 co-pay
Outpatient Hospital/Ambulatory Surgical Centers	$3 co-pay	$3 co-pay
Laboratory, Radiology and Diagnostic Services	$0 co-pay	$0 co-pay
Physician Services*	$2 co-pay	$0 co-pay
EPSDT Services for Children under 21	$0 co-pay	$0 co-pay
Maternity Services Nurse mid-wife services, pregnancy-related services and services for other conditions that might complicate pregnancy and 60 days postpartum pregnancy related services.	$0 co-pay	$0 co-pay
Preventive and Screening Services	$0 co-pay	$0 co-pay

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Durable Medical Equipment	3% coinsurance to maximum of $15 per month (NF residents' DME are included in NF rate)	3% coinsurance to maximum of $15 per month (NF residents' DME are included in NF rate)
Podiatry Services	$2 co-pay	$2 co-pay
Vision Services General ophthalmology and optometry	$2 co-pay	$0 co-pay $400 maximum on eyewear per 12 months; children under 21 ONLY
Dental Services Including but not limited to Children under 21, two cleanings per 12 months, one set of x-rays per 12 months, extractions. Adults 21 and over, one cleaning per 12 months, one set of x-rays and extractions	$2 co-pay	$0 co-pay
Family Planning Services and Supplies	$0 co-pay	$0 co-pay
Occupational Therapy	$0 co-pay	$0 co-pay 30 visits per 12 months
Physical Therapy	$0 co-pay	$0 co-pay 30 visits per 12 months

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Speech, Hearing and Language Therapy	$0 co-pay	$0 co-pay 30 visits per 12 months
Hospice (non-institutional)	$0 co-pay	$0 co-pay
Behavioral Health Services **	$0 co-pay	$0 co-pay
Transportation Services (as described in the current 1915b waiver)	$0 co-pay	$0 co-pay
Emergency Ambulance	$0 co-pay	$0 co-pay
Chiropractic Services	$2 co-pay Aged 21 & over, 15 visits per 12 months Under 21 years of age, 7 visits per 12 months	$0 co-pay Aged 21 & over, 15 visits per 12 months Under 21 years of age, 7 visits per 12 months
Prescription Drugs	For members who do NOT have Medicare Part D: $1 co-pay generic $2 co-pay preferred brand 5% coinsurance for non-preferred brand prescriptions	For members who do NOT have Medicare Part D: $1 co-pay generic $2 co-pay preferred brand 5% coinsurance for non-preferred brand prescriptions Limit of four prescriptions per month; maximum of 3 brand
Emergency Room	5% coinsurance for non-emergent visits	5% coinsurance for non-emergent visits
Hearing and Audiometric Services	$2 co-pay	$0 co-pay $1,400 maximum per ear every 36 months; children under 21 ONLY: 1 audiologist visit per 12 months

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Prosthetic Devices	$0 co-pay	$0 co-pay
Home Health Services	$0 co-pay	$0 co-pay
End Stage Renal Disease and Transplants	$0 co-pay	$0 co-pay

* **Physician Services** include physicians, certified pediatric and family nurse practitioners, nurse midwives, FQHCs, rural health clinics and physician assistants.

Behavioral Health Services include mental health rehab/stabilization, behavioral support, psychological services and inpatient psychiatric services under the age of 21.

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Disease Management and Get Healthy Benefits

Kentucky Medicaid will offer the following disease management programs described on pages 10.26through 10.40.

- Diabetes Initiative
- COPD/Adult Asthma Initiative
- Pediatric Obesity Initiative
- Cardiac – Heart Failure Initiative
- Pediatric Asthma Initiative

Medicaid members may select from one of the following Get Healthy Benefits upon successful participation for one year in a disease management program and completion of a Centers for Disease Control and Prevention recommended age and periodicity screening guidelines:

- Limited allowance for dental services not to exceed $50
- Limited allowance for vision hardware services not to exceed $50
- Five visits to a nutritionist (registered dietician) for meal planning and counseling
- Two months of smoking cessation through a local health department, including two months of nicotine replacement therapy

Members will have six months after selecting a Get Healthy Benefit to access the benefit. Failure to access the benefit in within six months will result in loss of the benefit.

Additionally, any individual who no longer participates in the Medicaid program will be immediately ineligible to access a Get Healthy Benefit.

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Diabetes Initiative

Program Description

The Department for Medicaid Services (DMS), Division of Medical Management and Quality Assurance (MMQA) implemented this initiative to provide the following goals:

- To improve quality of life for members with diabetes.
- To educate the members to be better prepared to manage their diabetes.
- Promote appropriate use of healthcare resources.
- Decrease work absences.
- Improve self-management of diabetes.
- Standards of Care adopted and guidelines followed by providers and members.

This initiative has targeted the age ranges of eighteen (18) years of age and older. The counties selected to participate in the pilot include Bell and Floyd.

Introductory letters were initially forwarded to providers and members. We wish to continue to encourage our healthcare providers for their input and assistance with this initiative. DMS MMQA continues to look forward to partnering with our providers, health departments and community resources to improve the lives of Kentuckians affected by diabetes.

Specific guidelines (for example) include the American Diabetes Association (ADA). A chart abstraction was performed that included diabetic history, symptoms/findings- blood pressure, A1c, proteinuria, lipid profile, microalbuminuria, foot exam, eye exam.

Member and provider mailings to continue every quarter. A newsletter is one format to provide educational information. Staff are available to assist with member calls, and nursing staff to answer questions as needed.

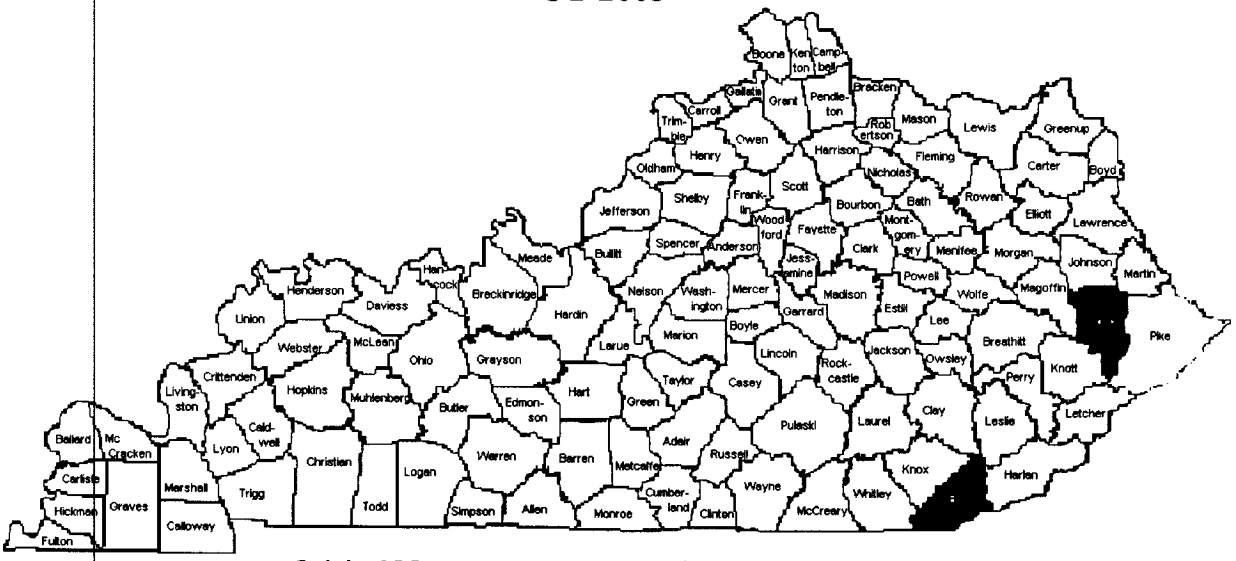
Clinical Guidelines and Standards

- American Diabetes Association (ADA)

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Summary Data and Map
Diabetes
Member Population = Females and Males with an age range over the age of 18
CY 2005



Original Member Letter and Provider Letter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count	Member Opt Out
BELL	526	24	13
Floyd	755	29	26
Grand Total	1,281	53	39

First Quarter Original Member Newsletter Mail Out

County Name	Unduplicated Member Count
BELL	513
Floyd	729
Grand Total	1,242

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Eye Brochure Original and First Quarter New Member Mail Out

County Name	Unduplicated Member Count	Member Opt Out	FH Identified	Undup. 1Q Member Count	GRNAD TOTAL FOR MAIL OUT
BELL	526	13	15	617	
Floyd	755	26	21	490	
Grand Total	1,281	39	36	1,107	2,078

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

COPD/Adult Asthma Initiative

Program Description

The Department for Medicaid Services Division of Medical Management and Quality Assurance has implemented the COPD/Adult Asthma Disease Management Program. The pilot counties selected include Letcher, Perry, and Whitley.

The goals of this program:

- Improve quality of life for members with COPD and /or asthma.
- Educate members to be better prepared to manage their COPD and/or asthma.
- Prevent acute exacerbations of asthma.
- Prevent admissions to the hospital and emergency department visits.
- Promote appropriate us of healthcare resources.
- Minimize work absences.

Introductory letters to be forwarded to healthcare providers and members. Members identified to have COPD and/or asthma will receive newsletters to include an example of an asthma action plan (following the National Heart, Lung, and Blood Institute Guidelines), COPD, asthma and smoking cessation educational information. The members will be encouraged to contact their healthcare providers to schedule an appointment for evaluation, and establishment of a plan of treatment.

The Department for Medicaid Services , Division of Medical Management and Quality Assurance to partner with our providers, health departments, and community resources to improve the lives of Kentuckians affected by COPD and/or asthma.

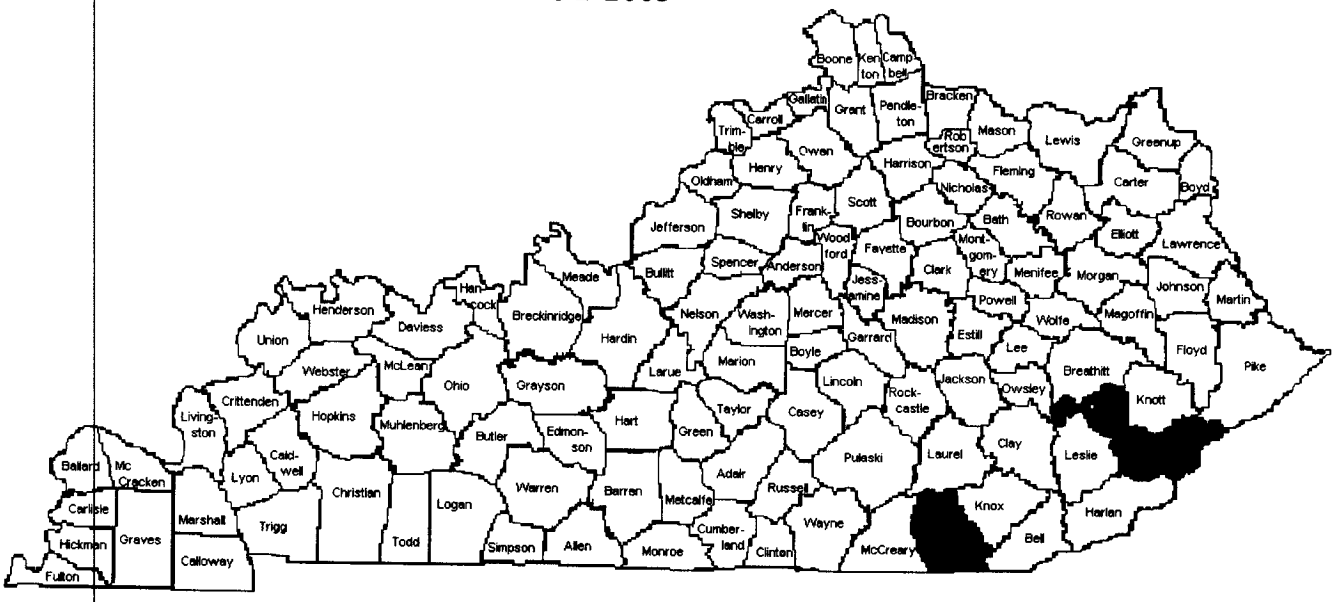
Clinical Guidelines and Standards

- National Heart, Lung, and Blood Institute (NHLBI)
- National Institutes of Health (NIH)

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Summary Data and Map
COPD / Adult Asthma
Member Population = Females and Males with an age range over the age of 18
CY 2005



Original Member Letter and Provider Letter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count
LETCHER	153	29
Perry	183	47
Whitley	211	62
Grand Total	547	138

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Pediatric Obesity Initiative

Program Description

The target population for this program is members age 5-12 identified with diagnosis of obesity.

The goals of this program are to:

- Improve the quality of life.
- Educate the parent and child to promote healthy weight and physical activity.
- Prevent medical complications and co-morbidity's.
- Promote appropriate use of heath care resources.
- Decrease school absences.
- Improve self-esteem.

The methods for identifying these members were paid claims and pharmacy data. We will also accept member and provider referrals to this program.

The Department for Medicaid Services, Division of Medical Management/Quality Assurance is asking the providers assistance in coordinating this implementation. We are planning to approach public health and the school system as partners in this program. The providers will receive a letter that includes a copy of the member letter, HRA assessment "Food for Thought" questionnaire and a tips for healthy eating and physical activity. The Regional Medicaid Nurse will be available to support this program via provider and member education.

Information will be distributed through mailings; the goal is to make this information available via web site, health fairs or classes and partnerships with pharmaceutical companies. This program will be implemented the week of September 26, 2005. Additional mailings will include educational materials on nutrition guidelines, food pyramid and physical activity education.

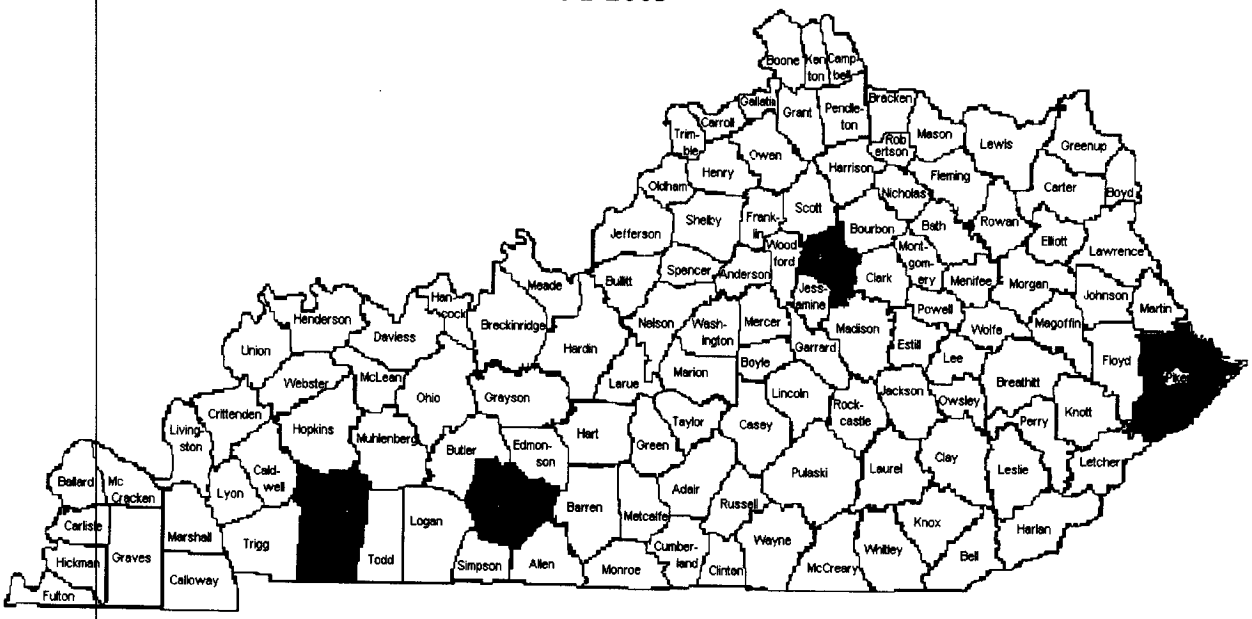
Clinical Guidelines and Standards

- Center for Disease Control (CDC)
- National Heart, Lung, and Blood Institute (NHLBI)
- American Academy of Pediatrics (AAP)

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Summary Data and Map
Pediatric Obesity
Member Population = Females and Males with an age range 5 to 12
CY 2005



Original Member Letter and Provider Letter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count	Member Opt Out
CHRISTIAN	41	33	3
Fayette	92	95	2
Pike	124	65	0
Warren	16	53	0
Grand Total	273	246	5

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

First Quarter Original and New Member Newsletter and Provider Newsletter Mail Out

County Name	Unduplicated Member Count	Unduplicated 1Q New Member Count	Members found in both original and 1Q Data	Provider Count
CHRISTIAN	39	13	12	33
Fayette	90	95	51	95
Pike	124	58	49	65
Warren	16	27	10	53
Grand Total	269	193	122	246

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Cardiac – Heart Failure Initiative

Program Description

The first initiative for the Cardiac Disease Management Program will be Heart Failure. The target population for this program is members 20 years and older (including dual members of Medicare and Medicaid) identified with diagnosis of Heart Failure. We will exclude diagnosis of heart failure with renal failure requiring renal dialysis and members in long term care facilities.

The goals of this program are:

- To improve quality of care.
- Prevent or delay complications.
- Promote continuity of care.
- Promote efficient use of healthcare resources.
- Improve self-management of heart failure.

The methods for identifying these members were paid claims and pharmacy data. We will also accept member and provider referrals to this program.

The Department for Medicaid Services, Division of Medical Management/Quality Assurance is asking the providers assistance in coordinating this implementation. We are partnering with the Kentucky Heart Disease and Stroke Prevention Program in the Department of Public Health and the American Heart Association. The providers will receive a newsletter containing some of the educational information that was provided in the member's newsletter, and "Tracking Your Symptoms" chart. Also included in the provider packet will be the American Heart Association "Get With The Guideline[sm] – Heart Failure" and the web site for "The American College of Cardiology/American Heart Association (ACC/AHA) 2005 Practice Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult" summary article. The Medicaid Nurse will be available to support this program via provider and member education.

Educational materials and information will be distributed through mailings. The goal is to make these educational materials and information available via the World Wide Web, health fairs or classes and partnerships with pharmaceutical companies. This program will be implemented the week of October 21, 2005. Additional mailings will include educational materials on specific topics concerning Heart Failure.

"The American College of Cardiology/American Heart Association 2005 Practice Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult" and the American Heart Association "Get With The Guideline[sm]-Heart Failure" are the guidelines used in this Cardiac Disease Management program.

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Clinical Guidelines and Standards

- "American College of Cardiology / American Heart Association 2005 Guidelines for Heart Failure Update for the Diagnosis and Management of Chronic Heart Failure".
- AHA "Get With The Guideline[sm] – Heart Failure".
- QAPI Heart Failure Quality Indicators.

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Summary Data and Map
Cardiac – Heart Failure Initiative
Member Population = Females and Males of all ages
CY 2005

Original Member Newsletters and Provider Newsletter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count
CLAY	139	50
Fayette	272	131
McCreary	99	32
Grand Total	510	213

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Pediatric Asthma Initiative

Program Description

The Department of Medicaid Services (DMS), Division of Medical Management and Quality Assurance (MMQA) implemented this initiative to provide the following goals:

- To improve quality of life for children with asthma.
- To educate the parent and child to be better prepared to manage asthma.
- To prevent acute exacerbations of asthma episodes.
- Promote appropriate use of healthcare resources.
- Decrease school absences.
- Improve self-management of asthma.

This initiative has targeted the age ranges of five (5) to seventeen (17) years of age. The counties selected to participate in the pilot include Perry, Pike and Powell.

An introduction letter was previously forwarded to providers and members. We wish to continue to encourage our healthcare providers for their input and assistance with this initiative. DMS MMQA continues to look forward to partnering with our providers, health departments and community resources to improve the lives of Kentuckians affected by asthma.

We have adopted specific guidelines for example of the National Heart, Lung, and Blood Institute (NHLBI). A chart abstraction was performed that included demographics, history, medications, utilization of services and education.

First mailing (for example) included an Asthma Action Plan (source: NHLBI) and Asthma Fact Sheet with information about "Asthma Is a Lung Disease", and "Managing Asthma and Asthma Triggers". Staff are available to assist with member calls, and nursing staff to answer questions as needed.

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

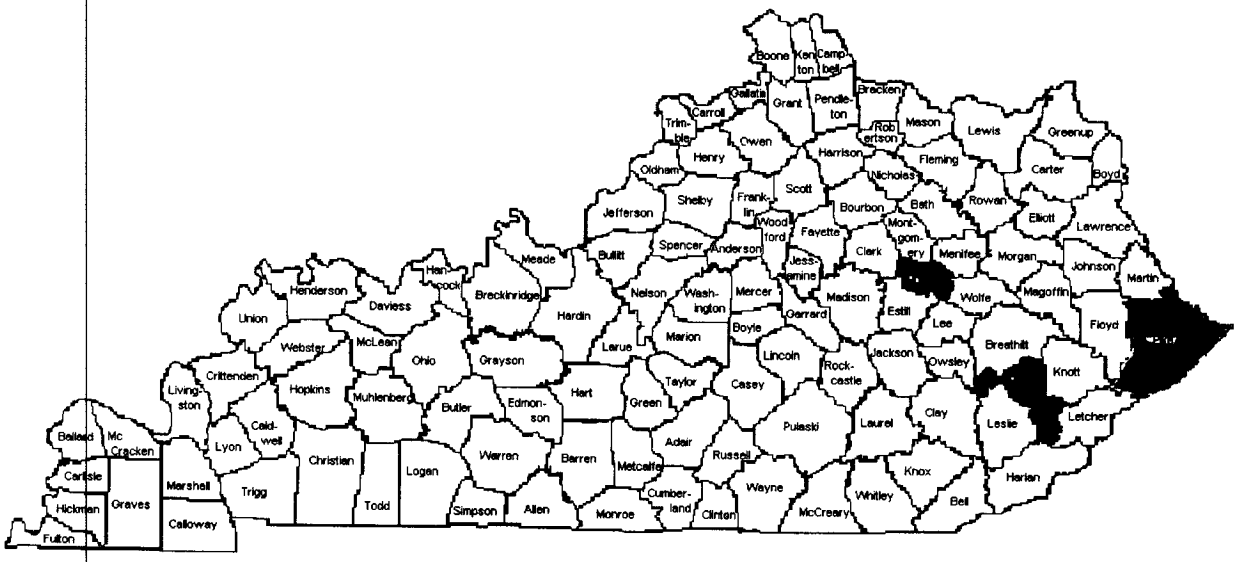
Clinical Guidelines and Standards

- National Heart, Lung, and Blood Institute (at this time, we have adopted primarily) (NHLBI)
- National Institutes of Health (NIH)

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Summary Data and Map
Pediatric Asthma
Member Population = Females and Males with an age range 5 to 17
CY 2005



Original Member Letter and Provider Letter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count	Member Opt Out
PERRY	206	19	2
Pike	774	43	18
Powell	104	3	1
Grand Total	1,084	65	21

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

First Quarter Original and New Member Newsletter Mail Out

County Name	Unduplicated Member Count	Unduplicated 1Q New Member Count	GRAND TOTAL FOR 1Q MAIL OUT
PERRY	204	806	
Pike	755	1,504	
Powell	103	261	
Grand Total	1,063	2,571	3,634

BENEFITS

Commonwealth Essential

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Annual Deductible	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*

BENEFITS

Commonwealth Essential

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits	Plan pays 100% up to a maximum of $200 per covered individual. Plan pays 100% of eligible immunizations.	
Emergency Services		
Emergency room treatment (Emergency room Co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*
Emergency room physician charges	25%*	50%*
Urgent care center treatment	25%*	50%*
Ambulance services	25%*	50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*	50%*
Prescription drugs – Retail (30 day supply)	25%	
	Min / Max	
1st Tier	$10 / $25	
2nd Tier	$20 / $50	
3rd Tier	$35 / $100	
Prescription drugs – Mail Order (90 day supply)	25%	
	Min / Max	
Generic	$20 / $50	
Preferred Brand	$40 / $100	
Non-preferred Brand	$70 / $200	
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*

BENEFITS

Commonwealth Essential

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Autism Service Rehabilitative and therapeutic care services	25%*	50%*
Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*
Prosthetic devices	25%*	50%*
Home health – limited to 60 visits per year	25%*	50%*
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*

*Services subject to deductible